BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ROSLYN RICE, Claimant, v. BASIC AMERICAN FOODS, Employer, and LIBERTY MUTUAL FIRE INSURANCE COMPANY, Surety, Defendants.	)	**IC 85-504159** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** FILED JUNE 24 2005

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Commission assigned this matter to Referee Douglas A. Donohue. He conducted a hearing in Idaho Falls, Idaho, on January 12, 2005. Delwin W. Roberts represented Claimant. Monte R. Whittier represented Defendants. The parties submitted briefs and the case is now ready for decision.

ISSUES

After due notice and by agreement of the parties, the following issues remain to be decided:

1. Whether and to what extent Claimant is entitled to the following benefits:

   (a) medical care; and
   (b) attorney fees; and

2. Whether the Industrial Commission should retain jurisdiction beyond the statute of limitations.

CONTENTIONS OF THE PARTIES

Claimant contends she injured her back in 1984. Surgery was performed and Claimant was told by her physician to expect a future surgery. A lump sum settlement agreement was reached which left open the obligation for payment of future medical care. In 2001, Claimant contacted Surety to request approval for the long-anticipated surgery. Surety told her the statute of limitations had run and denied liability. Claimant obtained the surgery by paying through her health insurance. Defendants acted unreasonably by asserting a statute of limitation as the basis for denying medical care, and continuing to deny benefits, and acted unreasonably by asserting causation and other defenses which were withdrawn just before the hearing.

Defendants contend Surety erroneously denied coverage because the adjuster was "new." Defendants admit it is "technically true" that the medical care was paid through Claimant's health insurance and "not through the worker's compensation surety." Employer paid the majority of Claimant's medical bills as a "self-insured" employer. Defendants contend Employer "for the most part complied with Idaho Code § 72-432." Claimant's only out-of-pocket expenses are $268.50 plus some co-payments for prescriptions. Defendants offered to reimburse Claimant's out-of-pocket expenses before the Complaint in this matter was filed. Claimant failed to show how much she paid out of pocket. Claimant would gain no benefit from an order requiring Employer to pay benefits because Employer already did so through its self-insured-health-benefits plan. Defendants suggest the Commission order in this matter should require Defendants to pay $851.11 plus other out-of-pocket expenses not yet documented and to pay attorney fees of $212.79. Employer opposes the idea of a subrogation against itself where its workers' compensation hand pays back its health insurance hand. Such a subrogation offers Claimant no benefit.

EVIDENCE CONSIDERED

The record in the instant case consists of the following:

1. Oral testimony at hearing by Claimant;

2. Claimant's exhibits A – H (page 74 of exhibit B is unrelated to Claimant and disregarded by the Referee); and

3. Defendants' exhibits A – H.

PRELIMINARY MOTION

After the hearing, Defendants moved to strike the first two sentences on page 8 of Claimant's brief. They asked for sanctions and moved that the case be dismissed. They also requested that the Referee be disqualified for having seen the allegedly prejudicial matter in Claimant's brief. Claimant filed a response and request for sanctions.

In their briefs, both parties made reference to settlement negotiations. Such remarks are deemed stricken. Whether a party did or did not negotiate or negotiated without good faith is not relevant to any issue for hearing. It cannot be a basis for considering attorney fees under Idaho Code § 72-804 without inviting more such allegations and invading the cloak over settlement negotiations, which cloak is vital to encouraging the parties to discuss settlement.

All other aspects of Defendants' motion are denied. Referees are often exposed to prejudicial matter. Here, such matter can be and is set aside by the Referee and is allowed no weight in the decision process.

As a side note, the Referee is dismayed by the *ad hominem* attacks in the briefs of both sides. Such are not persuasive and actually serve to undermine the attacker's own arguments.

FINDINGS OF FACT

1. Claimant began working for Employer about 1981. In late 1984, she suffered a compensable low back injury. She received medical care, including a surgery on May 6, 1985, which was performed by Thomas J. Setter, M.D. Though improved, she suffered symptoms postoperatively. She was released to return to work with restrictions as of June 23, 1985. She returned to work, and her symptoms increased. She continued to work and received follow-up care. A second low back surgery, a laminectomy and fusion, was performed May 14, 1986. She continued to work for Employer. Dr. Setter's records indicate the fusion did not become solid within the time frame expected. Dr. Setter provided an impairment rating in August 1987.

2. Claimant returned to Dr. Setter in April 1988. At that time, Dr. Setter opined future surgery might be necessary and recommended annual visits to assess her back condition. Dr. Setter's last medical record relates to a visit in October 1993.

3. A lump sum settlement agreement was entered into about September 1991. The parties do not dispute that medical benefits to that date and income benefits were resolved by that agreement. Future medical benefits remained open.

4. In 2001, Claimant's symptoms increased until she sought medical care. She first contacted Surety. Surety referred her to David Simon, M.D. Claimant made the appointment. Three days before her first visit to Dr. Simon, Surety telephoned Claimant and denied liability alleging a statute of limitation precluded liability. Claimant attended the appointment and began treatment, eventually leading to a surgery performed by Benjamin Blair, M.D. Dr. Blair diagnosed a failed fusion.

5. Claimant's health insurance paid a portion of these medical bills. Claimant made out-of-pocket payments for deductible and co-payment amounts also. At the time of Claimant's

deposition on April 12, 2004, Claimant believed charges in the range of ten or eleven thousand dollars had not been paid by her or by health insurance on her behalf. As both Claimant and her husband worked for Employer, both had health insurance benefits which contributed to paying the medical bills. A withholding for health insurance was taken from Claimant's and her husband's paychecks.

6. Claimant's employment was terminated September 16, 2002. Her husband continued to work for Employer. His health insurance paid some of the medical bills.

7. On September 23, 2002, Dr. Blair opined Claimant's need for additional surgery was caused by the 1984 injury.

8. Claimant's back fusion in 2002 left her with symptoms which indicated it may not have become solid. On September 7, 2004, Dr. Blair opined a repeat fusion was "a reasonable option."

Discussion and Further Findings

9. **Medical care.** Idaho Code § 72-432 requires an employer to provide reasonable care for a reasonable time. There is no cut-off or deadline beyond which the mere passage of time automatically makes medical care noncompensable. Dr. Setter warned Defendants about the possibility of future surgery. Claimant's low back condition from 2001 to the date of hearing was caused by the 1984 injury and failure of the 1986 fusion to become solid. The medical care provided was reasonable. Defendant has offered no basis upon which the medical care became noncompensable. Claimant is entitled to medical benefits for her low back condition from 2001 through the date of hearing.

10. Claimant established at hearing the amount of such medical care has been $67,140.49. Defendants' arguments that Claimant's medical benefits should be limited to her

out-of-pocket expenses are not persuasive. The statutory benefit is what the statute says it is. Only after the compensability of the full benefit is determined can questions of offset or subrogation affect the amount an employer or surety ultimately pays.

11. Defendants are liable for medical benefits in the full amount stated. The Commission's decision in Sangster v. Potlatch Corp., Idaho Code 01-008322 (Nov. 6, 2004) is instructive. Physicians providing treatment in the workers' compensation system are entitled to be paid according to the statutes and regulations promulgated, and not for some lesser amount determined by a health insurance company. Defendants are entitled to credit only for those dollars actually paid and not for amounts negotiated or compromised, if any. Whether Employer's other pocket wants it or not (as indicated by Defendants' exhibit H), the credited amount must be properly accounted for under the workers' compensation system.

12. **Attorney fees.** At the time of the lump sum settlement agreement, Claimant and Defendants held open the benefit for future medical care. They were aware that additional back surgery remained a possibility. When the time for that surgery arrived, Surety denied liability, falsely claiming a statute of limitation defense. Surety could have remedied its error at any time. It did not do so, but rather shifted to other defenses without evidence or basis. It waited until shortly before the hearing to drop the asserted defenses. Surety's actions were unreasonable.

13. Defendants argue their actions were reasonable because most of Claimant's bills were paid by Employer through its self-insured health care plan. Idaho Code § 72-301 legislates acceptable ways to conform to Idaho Workers' Compensation Law. Defendants' actions do not conform. Moreover, the obvious costs of premiums withheld and out-of-pocket costs are inconsistent with the statutory scheme. Add to that the fact that Claimant no longer works for Employer and it is her husband's health plan that must pay for medical care. One need not

consider whether methods of denying portions of care or setting ceilings on payments, which methods are commonly used by health insurance companies, happened here. Defendants did not obey the statutes. They did not correct the violation when apprised of it. Instead, they argued Claimant's attorney had bad motives.

14. Claimant's request for an award of attorney fees in the amount of $20,142.15 appears reasonable and within the regulatory requirements. Claimant should be awarded attorney fees in this amount.

15. **Retention of jurisdiction.** Here, Claimant has not shown a persuasive basis for retaining jurisdiction. No potential income benefits are at issue or likely to arise in the future.

CONCLUSIONS OF LAW

1. Claimant is entitled to $67,140.49 in medical benefits and for additional future medical care to her low back, if any. Defendants are entitled to credit only for those dollars actually paid.

2. Claimant is entitled to attorney fees in the amount of $20,142.15.

3. There exists no basis for retention of jurisdiction.

RECOMMENDATION

The Referee recommends that the Commission adopt the foregoing findings of fact and conclusions of law and issue an appropriate final order.

DATED this 9TH day of June, 2005.

INDUSTRIAL COMMISSION

/S/_____
Douglas A. Donohue, Referee

ATTEST:

/S/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 24TH day of June, 2005, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

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db /S/_____